

HOW I DO IT

Avoidance of Rectovaginal Fistula as a Complication After Low Anterior Resection for Rectal Cancer Using a Double-Stapling Technique

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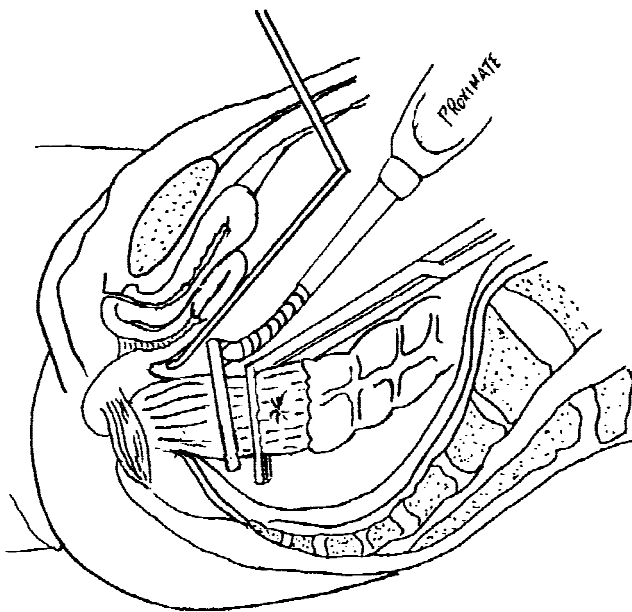


Fig. 1. An ACCESS 55™ stapler is placed for vertical occlusion of the rectum.

A rectovaginal fistula (RVF) associated with a double-stapled anastomosis in low anterior resection for rectal cancer is found at a surprisingly high rate, although this complication has received little attention [1]. Much evidence has accumulated which suggests that the posterior wall of the vagina becomes involved in the circular stapled anastomosis, thereby causing the fistula [2]. To prevent this complication, we have developed a new technique in which we use an ACCESS 55™ (Ethicon, Inc., Somerville, NJ) for vertical occlusion of the rectum (Fig. 1) and a PPCEE 31™ stapler (United States Sur-

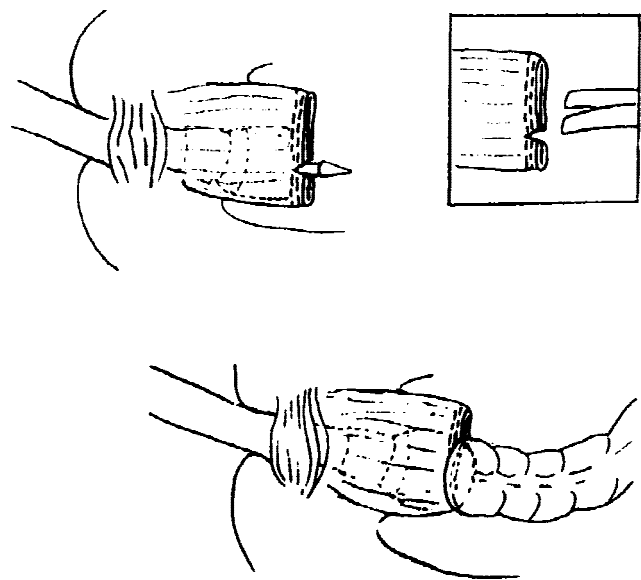


Fig. 2. A PPCEE 31™ stapler is fired to produce the anastomosis between the proximal colon and the posterior side of the rectal wall.

gical Corp.) for the anastomosis between the proximal colon and the posterior side of the rectal wall (Fig. 2).

Our new technique enables the surgeon to keep the posterior vaginal wall separate from the colorectal anastomosis site, and thereby eliminates the danger of the posterior vaginal wall becoming caught in the circular

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stapled anastomosis. The ACCESS 55™ stapler is suitable for the vertical occlusion of a rectal stump because its shaft is flexible and its head is movable. This technique is a feasible, safe, and easy procedure for performing low colorectal anastomosis. We believe that the proper use of an ACCESS 55™ stapler, combined with a PPCEEATM stapler, and awareness of this possible complication in female patients, may prevent an RVF after

low anterior resection using the double-stapling technique for rectal cancer.

REFERENCES

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